Respondent's address of record which, pursuant to California Code of Regulations, title 16, section 1409.1, is required to be reported and maintained with the Board, which was and is: 5430 Oak Park Lane, Unit 234 Oak Park, CA 91377.

- 4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c) and/or Business & Professions Code section 124. Respondent never filed a Notice of Defense.
  - 5. California Government Code section 11520 states, in pertinent part:
  - (a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.
- 6. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on the relevant evidence contained in the Default Decision Evidence Packet in this matter, as well as taking official notice of all the investigatory reports, exhibits and statements contained therein on file at the Board's offices regarding the allegations contained in Accusation No. 2012-718, finds that the charges and allegations in Accusation No. 2012-718, are separately and severally, found to be true and correct by clear and convincing evidence.
- 8. Taking official notice of its own internal records, pursuant to Business and Professions Code ("Code") section 125.3, it is hereby determined that the reasonable costs for Investigation and Enforcement is \$9,951.50 as of July 23, 2012.

#### DETERMINATION OF ISSUES

- 1. Based on the foregoing findings of fact, Respondent Solomon Quesada Baisa has subjected his Registered Nurse License No. 678333 to discipline.
  - 2. The agency has jurisdiction to adjudicate this case by default.
- 3. The Board of Registered Nursing is authorized to revoke Respondent's Registered Nurse License based upon the following violations alleged in the Accusation which are supported by the evidence contained in the Default Decision Evidence Packet in this case.

a. Respondent is subject to disciplinary action under Business and Professions Code (the Code) section 2761, subdivision (a), for unprofessional conduct and section 2762, subdivision (a), for possession of controlled substances and section 2762, subdivision (e), for falsification of records because Respondent withdrew narcotics without a physician's orders, withdrew narcotics for patients not assigned to him, failed to properly chart narcotics or follow physician orders and withdrew larger doses of narcotics than ordered by a physician. The conduct is described in more particularity in Accusation No. 2012-718, inclusive and herein incorporated by reference.

## **ORDER** IT IS SO ORDERED that Registered Nurse License No. 678333, heretofore issued to Respondent Solomon Quesada Baisa, is revoked. Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute. This Decision shall become effective on December 7 It is so ORDERED NOVEMBER 8, 2012 FOR THE BOARD OF REGISTERED NURSING DEPARTMENT OF CONSUMER AFFAIRS 51015372.DOC DOJ Matter ID:LA2011601501 Attachment: Exhibit A: Accusation Case No. 2012-718

# Exhibit A

Accusation Case No. 2012-718

1		
2	KAMALA D. HARRIS Attorney General of California KAREN B. CHAPPELLE Supervising Deputy Attorney General GLORIA A. BARRIOS Supervising Deputy Attorney General	
3		
4		
5	State Bar No. 94811 300 So. Spring Street, Suite 1702	
6	Los Angeles, CA 90013 Telephone: (213) 897-2540	
7	Facsimile: (213) 897-2804	
8	Attorneys for Complainant	,
9 -	BEFORE THE BOARD OF REGISTERED NURSING DEPARTMENT OF CONSUMER AFFAIRS STATE OF CALIFORNIA	
10		
11		2212 - 718
12	In the Matter of the Accusation Against:	Case No. 2012 - 718
13	SOLOMON QUESADA BAISA	ACCUSATION
14	5430 Oak Park Lane Unit 234 Oak Park, CA 91377	
15		
16	Registered Nurse License No. 678333	
17	Respondent.	
18 19	Complainant alleges:	
20	PARTIES  1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.	
21		
22		
23		
24	2. On or about April 25, 2006, the Board of Registered Nursing (Board) issued	
25	Registered Nurse License No. 678333 to Solomon Quesada Baisa (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2013, unless renewed.	
26		
27		
28		// .
		1 .

.28

#### **JURISDICTION**

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

### STATUTORY PROVISIONS

4. Section 492 states:

"Notwithstanding any other provision of law, successful completion of any diversion program under the Penal Code, or successful completion of an alcohol and drug problem assessment program under Article 5 (commencing with section 23249.50) of Chapter 12 of Division 11 of the Vehicle Code, shall not prohibit any agency established under Division 2 commencing with Section 500) of this code, or any initiative act referred to in that division, from taking disciplinary action against a licensee or from denying a license for professional misconduct, notwithstanding that evidence of that misconduct may be recorded in a record pertaining to an arrest.

"This section shall not be construed to apply to any drug diversion program operated by any agency established under Division 2 (commencing with Section 500) of this code, or any initiative act referred to in that division."

- 5. Section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.
  - 6. Section 2761 states, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

- "(a) Unprofessional conduct"
- 7. Section 2762 states, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

8. Section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

### **COST RECOVERY**

9. Section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

#### **CONTROLLED SUBSTANCE**

- 10. **Hydromorphone Hydrochloride (Dilaudid)** a Schedule II controlled substance pursuant to Health and Safety Code section 11055, (b)(1)(j) and is categorized a dangerous drug pursuant to Business and Professions Code section 4022. It is a narcotic analgesic used for the relief of severe pain.
- 11. **Percocet (Oxycodone)** a Schedule II controlled substance pursuant to Health and Safety Code section 11055, (b)(1) and is categorized a dangerous drug pursuant to Business and Professions Code section 4022. Oxycodone is for use in opiate tolerant patients only.
- 12. **APAP/Oxycodone (Endocet)** a Schedule II controlled substance with acetaminophen, pursuant to Health and Safety Code section 11055, (b)(1)(m) and is categorized a

dangerous drug pursuant to Business and Professions Code section 4022. Oxycodone is a synthetic opiate that can cause intense euphoria, relaxation, and sedation.

13. **Lorazepam**— a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, (d)(16) and is categorized a dangerous drug pursuant to Business and Professions Code section 4022. Lorazepam is an antianxiety agent.

#### FIRST CAUSE FOR DISCIPLINE

## (Unprofessional Conduct)

- 14. Respondent is subject to disciplinary action under section 2761, in that Respondent committed unprofessional conduct as follows:
- 15. Respondent was employed as a registered nurse in the Telemetry Unit of Marina Del Rey Hospital ("Hospital") from about April 4, 2009, to about April, 2011. At all times relevant to the charges herein, the Hospital used a drug dispensing system called the "Pyxis System". The Pyxis is a computerized automated medication dispensing machine. The user enters a password to gain access and dispense medication from the machine. The machine records the user name, patient name, medication, dose, date and time of the withdrawal. The Pyxis is integrated with hospital pharmacy inventory management systems.
- 16. On or about April, 2011, Respondent was terminated from the Hospital for failing to respond to the Hospital's investigation involving a routine audit of his narcotic transactions. The Hospital's audit revealed several discrepancies in Respondent's narcotic transactions. The audit revealed that Respondent withdrew narcotics without a physician's orders, withdrew narcotics for patients not assigned to him, failed to properly chart narcotics or follow physician orders, and withdrew larger doses of narcotics than ordered by a physician. The Hospital's audit revealed the following discrepancies:

26 | ///

## PATIENT W.D. (#8102019950)<sup>1</sup>

- a. On or about April 30, 2011, Respondent removed 4 mg/ml of Dilaudid from Pyxis at 0722. There was no physician order. Respondent did not document that he administered any Dilaudid to the patient. At 1738, he wasted the 4 mg/ml of Dilaudid.
- b. On or about April 30, 2011, Respondent removed 2 mg/ml of Dilaudid from Pyxis at 1213. There was no physician order. Respondent did not document that he administered any Dilaudid to the patient. At 1607, he returned the 2 mg/ml of Dilaudid. Medication is rarely returned.
- c. On or about April 30, 2011, Respondent removed 4 mg/ml of Dilaudid from Pyxis at 1359. There was no physician order. Respondent did not document that he administered any Dilaudid to the patient. At 1606, he returned the 4 mg/ml of Dilaudid. Medication is rarely returned.

## PATIENT D.M. (#8102015586)

- a. On or about May 13, 2011, Respondent removed 4 mg/ml of Dilaudid from Pyxis at 0718. On or about May 13, 2011, Respondent removed 4 mg/ml of Dilaudid from Pyxis at 1259. The physician's order called for .5 mg/ml of Dilaudid by IV push every 2 hours as needed for pain. Despite the fact that the physician's order called for .5 mg/ml, Respondent removed 4 mg/ml vials of Dilaudid instead of 2 mg/ml vials.
- b. Respondent failed to follow the physician's orders in that he documented in the Medication Administration Record (MAR) he had administered .5 mg/ml of Dilaudid to the patient at 0725 and through his Pyxis report at 0821 (less than 1 hour apart). The physician's order called for .5 mg/ml of Dilaudid by IV push every 2 hours as needed for pain.

## PATIENT J.C. (#8102023697)

a. Respondent failed to follow the physician's orders in that his Pyxis report and the MAR show that on April 30, 2011, he administered .2 mg/ml of Dilaudid to the patient every 35-

<sup>&</sup>lt;sup>1</sup> All patients will be referred to by their initials and medical record numbers to protect their privacy.

50 minutes from 1430 through 1845 (6 times). The physician's order called for 1 mg/ml of Dilaudid every 4 hours as needed for pain.

b. On or about April 30, 2011, Respondent removed 4 mg/ml of Dilaudid from Pyxis at 1430. On or about April 30, 2011, Respondent removed 4 mg/ml of Dilaudid from Pyxis at 1735. On or about April 30, 2011, Respondent removed 4 mg/ml of Dilaudid from Pyxis at 1827. The physician's order called for 1 mg/ml of Dilaudid every 4 hours as needed for pain. Despite the fact that the physician's order called for 1 mg/ml, Respondent removed 4 mg/ml vials instead of 2 mg/ml vials.

## PATIENT C.C. (#810203065)

- a. Respondent failed to follow the physician's orders in that his Pyxis report shows that on May 13, 2011, he administered .5 mg/ml of Dilaudid to the patient every 3 hours, 15 minutes-1 hour and 15 minutes from 1315 through 1748 (3 times). The physician's order called for .5 mg/ml of Dilaudid every 4 hours as needed for pain. There was no MAR.
- b. On or about May 13, 2011, Respondent removed 4 mg/ml of Dilaudid from Pyxis at 1634. On or about May 13, 2011, Respondent removed 4 mg/ml of Dilaudid from Pyxis at 1748. The physician's order called for .5 mg/ml of Dilaudid every 4 hours as needed for pain. Despite the fact that the physician's order called for .5 mg/ml of Dilaudid, Respondent removed 4 mg/ml vials instead of 2 mg/ml vials. There was no MAR.

#### PATIENT P.K. (#8102037085)

- a. On or about May 18, 2011, Respondent removed 4 mg/ml of Dilaudid from Pyxis at 0723. There was no physician order. Respondent did not document that he administered any Dilaudid to the patient. He wasted the 4 mg/ml of Dilaudid.
- b. On or about May 18, 2011, Respondent removed 2 mg/ml of Dilaudid from Pyxis at 1603. There was no physician order. Respondent did not document that he administered any Dilaudid to the patient. He returned the 2 mg/ml of Dilaudid.

#### PATIENT A.H. (#8102042390)

a. On or about May 18, 2011, Respondent removed 4 mg/ml of Dilaudid from Pyxis at 1824. The physician's order called for 1 mg/ml of Dilaudid every 6 hours as needed for pain.

2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27

1

Despite the fact that the physician's order which called for 1 mg/ml of Dilaudid, Respondent removed 4 mg/ml vial instead of 2 mg/ml vial.

#### PATIENT A.G. (#8102032201)

a. On or about May 18, 2011, Respondent removed 4 mg/ml of Dilaudid from Pyxis at 1217. The physician's order called for 1 mg/ml of Dilaudid every 3 hours as needed for pain. Despite the fact that the physician's order which called for 1 mg/ml of Dilaudid, Respondent removed 4 mg/ml vial instead of 2 mg/ml vial.

### SECOND CAUSE FOR DISCIPLINE

#### (Possession of Controlled Substances)

- 17. Respondent is subject to disciplinary action under section 2762, subdivision (a) in that Respondent withdrew controlled substances/dangerous drugs, but either withdrew narcotics without a physician's orders, withdrew narcotics for patients not assigned to him, failed to properly chart narcotics or follow physician orders, and withdrew larger doses of narcotics than ordered by a physician. Complainant refers to and incorporates all of the allegations in paragraph 16, as though set forth fully.
- 18. Respondent is subject to disciplinary action under section 2762, subdivision (a) in that Respondent obtained several prescriptions of controlled substances/dangerous drugs from three physicians without informing them that he was receiving the same drugs from the other physicians at the same time.
- a. On or about October 28, 2010, Respondent filled a prescription from Erwinn MartinC. Sistoza, M.D., for 90 tablets of Percocet, 325 10 mg.
- b. On or about November 5, 2010, Respondent filled a prescription from Dr. Sistoza, for 90 tablets of APAP/Oxycodone, 325 10 mg.
- c. On or about November 16, 2010, Respondent filled a prescription from Daniel Marcus, M.D., for 120 tablets of Oxycodone and Acetaminophen, 325 10 mg.

- d. On or about December 2, 2010, Respondent filled a prescription from Dr. Sistoza, for 120 tablets of Endocet, 325 10 mg.
- e. On or about December 15, 2010, Respondent filled a prescription from Dr. Marcus, for 120 tablets of Oxycodone and Acetaminophen, 325 10 mg.
- f. On or about December 26, 2010, Respondent filled a prescription from Dr. Marcus, for 120 tablets of APAP/Oxycodone, 325 10 mg.
- g. On or about January 6, 2011, Respondent filled a prescription from Dr. Sistoza, for 120 tablets of Oxycodone and Acetaminophen, 325 10 mg.
- h. On or about February 11, 2011, Respondent filled a prescription from Dr. Sistoza, for 120 tablets of APAP/Oxycodone, 325 10 mg.
- i. On or about February 20, 2011, Respondent filled a prescription from Dr. Sistoza, for
   90 tablets of APAP/Oxycodone, 325 10 mg.
- j On or about March 1, 2011, Respondent filled a prescription from Dr. Sistoza, for 90 tablets of APAP/Oxycodone, 325 10 mg.
- k. On or about March 11, 2011, Respondent filled a prescription from Dr. Marcus, for 120 tablets of APAP/Oxycodone, 325 10 mg.
- 1. On or about March 25, 2011, Respondent filled a prescription from Dr. Marcus, for 90 tablets of APAP/Oxycodone, 325 10 mg.
- m. On or about April 8, 2011, Respondent filled a prescription from Dr. Sistoza, for 90 tablets of APAP/Oxycodone, 325 10 mg.
- n. On or about April 19, 2011, Respondent filled a prescription from Dr. Marcus, for 90 tablets of APAP/Oxycodone, 325 10 mg.

- o. On or about May 4, 2011, Respondent filled a prescription from Dr. Sistoza, for 90 tablets of APAP/Oxycodone, 325 10 mg.
- p. On or about May 4, 2011, Respondent filled a prescription from Dr. Marcus, for 30 tablets of APAP/Oxycodone, 0.5 mg.
- q. On or about May 28, 2011, Respondent filled a prescription from Dr. Sistoza, for 120 tablets of APAP/Oxycodone, 325 10 mg.
- r. On or about June 7, 2011, Respondent filled a prescription from Dr. Marcus, for 120 tablets of APAP/Oxycodone, 325 10 mg.
- s. On or about June 16, 2011, Respondent filled a prescription from Narsis Khorasgani Moshfeghi, M.D., for 15 tablets of APAP/Oxycodone, 325 10 mg.
- t. On or about June 22, 2011, Respondent filled a prescription from Dr. Moshfeghi, for 90 tablets of APAP/Oxycodone, 325 10 mg.
- u. On or about June 25, 2011, Respondent filled a prescription from Dr. Sistoza, for 90 tablets of APAP/Oxycodone, 325 10 mg.
- v. On or about June 25, 2011, Respondent filled a prescription from Dr. Sistoza, for 30 tablets of Lorazepam, 0.5 mg.
- w. On or about July 4, 2011, Respondent filled a prescription from Dr. Marcus, for 120 tablets of APAP/Oxycodone, 325 10 mg.
- x. On or about July 17, 2011, Respondent filled a prescription from Dr. Marcus, for 120 tablets of APAP/Oxycodone, 325 10 mg.
- y. On or about July 25, 2011, Respondent filled a prescription from Dr. Sistoza, for 120 tablets of APAP/Oxycodone, 325 10 mg.

2

3

4

6

5

7

9

10

11

1213

14

15

16

17

18

19 20

21

22

LA2010601400 60602980.docx

Jz(4/18/11)

2324

25

2627

28

#### THIRD CAUSE FOR DISCIPLINE

## (Falsification of Records)

19. Respondent is subject to disciplinary action under section 2762, subdivision (e) in that Respondent falsified medical records when he withdrew controlled substances/dangerous drugs, but either withdrew narcotics without a physician's orders, withdrew narcotics for patients not assigned to him, failed to properly chart narcotics or follow physician orders, and withdrew larger doses of narcotics than ordered by a physician. Complainant refers to and incorporates all of the allegations in paragraph 16, as though set forth fully.

## **PRAYER**

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

- 1. Revoking or suspending Registered Nurse License No. 678333, issued to Solomon Quesada Baisa;
- 2. Ordering Solomon Quesada Baisa to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to section 125.3;
  - 3. Taking such other and further action as deemed necessary and proper.

DATED: May 30 2012

LOUISE R. BAILEY, M.ED., RN Interim Executive Officer

Board of Registered Nursing
Department of Consumer Affairs

State of California

Complainant